URINARY SYMPTOM ASSESSMENT and REFERRAL FORM

The Queen Elizabeth Hospital King's Lynn NHS

NHS Trust

Patient details

Name

Address

Hospital Number (if known)

NHS number

D.O.B

Most troublesome complaint:

Duration of symptoms:

Rapid progression?

Date of examination	Initial exam.	6/12	1 Year

Obstructive symptoms

How often	Never **0**	Sometimes **1**	Most of the time **2**	Always **3**
Do you have difficulty starting to pass water?				
Is the force of your urine stream reduced?				
Does your stream stop and start while you are passing water?				
After passing water do you feel your bladder is not completely empty?				

Score

0-4
5-8
9-12
Obstructive Score

Irritative symptoms

	0	**1**	**2**	**3**
How long do you go between visits to the toilet to pass water?	3 hours or longer	2-3 hours	1-2 hours	Less than 1 hour
How often are you woken to pass water during the night?	0-1	2-3	4-5	More than 5
How often do you have trouble holding onto your water after you feel, the urge to pass it?	Never	Some of the time	Most of the time	Always

Score

0-3
4-6
7-9
Irritative score

Quality of Life

If you were to spend the rest of your life with your urinary condition how would you feel?	Delighted **0**	Pleased **1**	Mostly Satisfied **2**	Mixed **3**	Mostly Dissatisfied **4**	Unhappy **5**	Terrible **6**

0-1
2-4
5-6

TOTAL SYMPTOM SCORE

05.11.03

Abdominal Examination	Bladder Palpable	YES ☐	NO ☐
Rectal Examination	Suspicious	YES ☐	NO ☐
Urinalysis	Haematuria	YES ☐	NO ☐
MSU	PSA		
Blood test	Creatinine		
Bladder scan/ uroflow test results			

Once this assessment has been undertaken…….

IF PSA IS RAISED USING AGE RELATED RANGES (SEE SUPPORTING INFORMATION DOCUMENT) PLEASE REFER THE PATIENT DIRECTLY THROUGH TO THE CANCER OFFICE BY TELEPHONE……01533 613626
IF PSA NORMAL …….

- **If mild symptoms and signs then surveillance is recommended**
- **Pharmocological treatment should be commenced for patients with moderate to severe symptoms (see supporting information sheet)**
- **Review the patients at 6 weeks or 3 monthly dependent on medication prescribed.**

Patients should only be referred to the Consultant if their symptoms do not improve or worsen after commencing medication and have been reviewed at 6 weeks / 3 monthly.
Please use and send /fax this completed form as a urology referral form 01553 613519.

Medical History Diabetes Yes ☐ / No ☐ Latest Blood pressure recording Current Medication	**Referring GP** Name Address Telephone Fax Number Please give reason for referral (e.g. failed treatment)

For Prostate Assessment Clinic Referral ☐	For Consultant Referral ☐	Date of referral	

GP SIGNATURE .....

For Prostate assessment clinic use
Uroflowmetry: **Average urinary flow** **Qmax) :…… (mls/sec**
Comments:……

Residual Urine:…… mls

Other investigations……